Application to Become an OCFS Service Provider

This form must be completed electronically and emailed, along with all requested supporting materials, to the Resource Coordinator associated with your agency's main office regional location. ***If you are applying to provide a service requiring a mental health license, please submit a copy of your current mental health license and approval letter before submitting this application.***

1. Please check which service(s) you are seeking to provide:
   - ☐TCM, Section 13
   - ☐RCS, Section 28
   - ☐Outpatient, Section 65
   - ☐Med Management, Section 65
   - ☐HCT, Section 65
   - ☐Other: Click here to enter text.

2. Which Resource Coordinator did you contact to initiate your agency's application process?
   Click to Choose One

Agency Demographics

1. Agency Name: Click here to enter text.
2. Agency Vendor Code: Click here to enter text.
3. Agency EIN Number: Click here to enter text.
4. Agency Location (Home/personal residences are not permitted):
   Click here to enter text.
5. Agency Mailing Address (if different than physical location): Click here to enter text.
6. Telephone: Click here to enter text. Fax: Click here to enter text.
   Cell: Click here to enter text. Email: Click here to enter text.
   TTY: Click here to enter text.

7. Check one:

   ☐ Non-Profit
   ☐ For Profit

8. Current Management Team:
   a. CEO/Executive Director: Click here to enter text.
   b. Clinical Program Manager: Click here to enter text.
   c. Finance Manager: Click here to enter text.
   d. IT Manager: Click here to enter text.

9. Please submit separate documentation with your proposal for each item listed below. Missing items may delay the application approval process.
   - Liability company and amount
   - Insurance company, type and amount of insurance (with face sheet)
   - Organizational Chart
   - Board of Directors (***Required for Non-Profit***)
   - Employee Handbook
   - Mission Statement
   - Vision Statement
   - Brochure
   - Background checks to include:
     - State Bureau of Investigation
     - Child Protective
     - Motor Vehicle - including the individual's name & license #
     - Federal Exclusions Program: https://oig.hhs.gov/exclusions/index.asp
     - Sex Offender Registry: http://sor.informe.org/cgi-bin/sor/index.pl
     - Is there any current investigation occurring at this time? Check one:

       ☐Yes ☐ No

       If yes, please explain: Click here to enter text.
   - Resumes of CEO and other relevant partners/managers
   - Licensing or Certifications Held
   - Quality Assurance plan (refer to #5 below)
   - Crisis plan (refer to #6 below)
   - Articles of Incorporation or Articles of Organization **(*For-Profit only*)**

Funding and Operations

1. How do you plan to be reimbursed for your services?
   Click here to enter text.

2. If MaineCare, which of the current MaineCare rules governing this service have you read?
   Click here to enter text.

3. If private insurance, please explain further:
   Click here to enter text.

4. Please explain your history of:
   a. Operating a business
      Click here to enter text.

b. Working with the population you propose to serve
   Click here to enter text.

5. It is the Department's expectation for each agency to conduct an annual comprehensive quality assurance/improvement review. Please describe in detail your agency's QA/QI process, how you determine areas to focus upon, how accomplishments are identified, use of outside professionals, etc.
   Click here to enter text.

6. Summarize your agency's crisis/safety planning process for:
   a. Clients:
      Click here to enter text.
   b. Staff:
      Click here to enter text.
   c. Agency-wide:
      Click here to enter text.

Proposed Service Model

Please describe, in detail, your Agency's:

1. Theoretical Framework (e.g. developmental, behavioral, ecological, etc.):
   Click here to enter text.

2. Vision for service:
   a. Explain how you plan to deliver the supports (i.e., How will the family benefit from working with your agency? How will your agency effectively deliver the service for which you are applying?, etc.)
      Click here to enter text.
   b. Geographic coverage
      Click here to enter text.
   c. Target Population (age, diagnosis, functional ability)
      Click here to enter text.
   d. Number of staff (including qualifications) projected to be hired in the first year:
      Click here to enter text.

3. Supervision structure and expectations, including frequency and duration, qualification of supervisors and consultants, amount of direct and group time, etc.
   Click here to enter text.

4. Evidence Based Practices (EBPs):

a. What specific EBPs does/will your agency use?
   Click here to enter text.
b. How will you incorporate EBPs in assessment, treatment planning, and treatment implementation?
   Click here to enter text.

5. Incorporation of the Trauma Informed (TI) System of Care Principles throughout your agency (*For more information, please refer to http://thriveinitiative.org/about/system-of-care/; http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf*):
   Click here to enter text.

6. Incorporation of co-occurring practices (*For more information, please refer to http://www.samhsa.gov/co-occurring*):
   Click here to enter text.

7. Justification for services: Why do you think this service is needed? Please provide specific instances where the need for this service was not met:
   Click here to enter text.

Training and Collaboration

1. Please explain in detail how you plan to address:
   a. Professional ethics
      Click here to enter text.
   b. Trauma informed care
      Click here to enter text.
   c. Co-occurring issues
      Click here to enter text.
   d. Boundary issues
      Click here to enter text.
   e. Family inclusion and participation
      Click here to enter text.
   f. Crisis/safety responses
      Click here to enter text.
   g. Mandated reporting
      Click here to enter text.
   h. Other: Click here to enter text.

Note: ***TCM providers must also adhere to additional core trainings expected by the Department. Please contact a Resource Coordinator for the list if needed.***

2. Please describe your experience with:

a. Working as a member of a team
   Click here to enter text.
b. Working collaboratively with communities and community partners
   Click here to enter text.

Any other additional information you would like to share about your agency:

Click here to enter text.

CONTACTS:

Please contact the Resource Coordinator associated with your agency's home office location for any assistance:

Region 1 (*Cumberland/York Counties*):

Cathy Register at 822-2331 or email Cathy.Register@maine.gov

Region 2 (*Androscoggin, Franklin, Oxford, Somerset, Kennebec, Lincoln, Waldo, Knox or Sagadahoc Counties*)

Kellie Pelletier at 624-7910 or email Kellie.A.Pelletier@maine.gov

Region 3 (*Penobscot, Piscataquis, Hancock, Washington, or Aroostook Counties*)

Cheryl Hathaway at 561-4204 or email Cheryl.Hathaway@maine.gov